General Assembly **Amendment**

February Session, 2006 LCO No. **4754**

HB0537204754HD0

Offered by:

REP. O'CONNOR, 35th Dist.
SEN. CRISCO, 17th Dist.
SEN. MURPHY, 16th Dist.
REP. SAYERS, 60th Dist.
SEN. GAFFEY, 13th Dist.
REP. OLSON, 46th Dist.
SEN. HARTLEY, 15th Dist.

To: Subst. House Bill No. **5372** File No. 281 Cal. No. 192

"AN ACT CONCERNING ACCESS TO IMAGING SERVICES."

Strike lines 1 to 30, inclusive, in their entirety and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2006*) (a) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under an individual health insurance policy or contract for magnetic resonance imaging or computed axial tomography may (1) require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services is not the same person or is not participating in the same group practice.

(b) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under an individual health insurance policy or contract for positron emission tomography may (1) require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service and the physician rendering such service is not the same person or is not participating in the same group practice.

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520 of the general statutes.

Sec. 2. (NEW) (*Effective October 1, 2006*) (a) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for magnetic resonance imaging or computed axial tomography may (1) require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services is not the same person or is not participating in the same group practice.

(b) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for positron emission tomography may (1) require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or (2) require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service

and the physician rendering such service is not the same person or is not participating in the same group practice.

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520 of the general statutes."